

## OCCUPATIONAL THERAPY ON ROAD DRIVING ASSESSMENT REFERRAL

### Client details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Funding: \_\_\_\_\_

### Referrer details:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

### General Practitioner (if different from Referrer):

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Date of referral:** \_\_\_\_\_

**Reason for referral:** \_\_\_\_\_

### Driving History: *Please note that the client must hold a valid licence or learner's permit.*

Drivers Licence: Type: \_\_\_\_\_ Licence No: \_\_\_\_\_ Expiry Date: \_\_\_\_\_

Licence Conditions: ☐ A (auto only) ☐ S (spectacles to be worn) ☐ V (vehicle modifications)

☐ M (medical condition); If yes, current medical certificate expiry date: \_\_\_\_\_

☐ Other: \_\_\_\_\_

Current Vehicle(s) Driven: \_\_\_\_\_

### Medical History:

Diagnosis and Date of Onset: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

### Current Functional Status:

Cognition: impaired / not impaired \_\_\_\_\_

Visual Perception: impaired /not impaired \_\_\_\_\_

Physical: impaired / not impaired \_\_\_\_\_

Vision Assessment: \_\_\_\_\_

**Hearing/ Other:** \_\_\_\_\_

### Driving Assessment Risk Screening – ***NB This field is Mandatory***

The following criteria may increase the risk of unsafe driving. To assist us in managing the referral, please complete the following checklist.

**If multiple factors are ticked please contact Occupational Therapy for advice BEFORE progressing this referral.**

- ☐ Co morbidity of the following diagnoses as per evidence/Austroads Guidelines(2012):
- |   |  |
|---|--|
| <input type="checkbox"/> Dementia >24 months  | <input type="checkbox"/> Post intracranial surgery   |
| <input type="checkbox"/> Parkinson's disease  | <input type="checkbox"/> Significant acquired brain injury                                 |
| <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Multiple sclerosis  |
| <input type="checkbox"/> NIDDM or IDDM        | <input type="checkbox"/> Cardiac arrest with chance of recurrence or other heart condition |
| <input type="checkbox"/> Recent stroke or TIA |  |
- ☐ Attention deficits
- ☐ **Active Mental Health Condition \*\* Please note patients with an active mental health condition are not eligible for this consultation \*\***
- ☐ Use of Benzodiazepines or Tricyclic antidepressants
- ☐ Previous close calls / accidents reported. If yes, please describe
- \_\_\_\_\_
- 

#### Urgency of referral:

- ☐ Urgent- public safety risk
- ☐ Requires appointment according to regular system of availability/ waiting list

**A waiting list may exist for In Room OT Driver Screening.** Please indicate below what advice you have provided to your client regarding their driving status whilst awaiting assessment.

- ☐ Must not drive whilst awaiting OT driver screening
- ☐ May continue to drive whilst awaiting OT driver screening
- ☐ May drive with conditions (list) whilst awaiting OT driver screening: \_\_\_\_\_
- 

#### Behaviour:

Are there any concerns regarding the client's ability to control anger/emotions? **Yes / No**

- Attitude towards assessment
- ☐ Understanding / compliant
- ☐ Resistant
- ☐ Hostile

#### Contact process:

- ☐ Contact client directly for appointment
- ☐ Contact referrer for further direction
- ☐ Other:

#### Medical Clearance for OT Driving Assessment

I \_\_\_\_\_ certify that my patient \_\_\_\_\_ is medically fit to undergo an occupational therapy driver screening.

Signed: \_\_\_\_\_

***Please also include visual acuity assessment results if completed***